

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN1909</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/27/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN HEALTH AND REHAB CEN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 HICKORY HOLLOW TERRACE</b> <b>ANTIOCH, TN 37013</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments  Complaint investigation of #TN0000052983, TN0000052263, TN0000053852, TN0000053798, TN0000053404 under 42 CFR PART 483, Requirements for Long Term Care Facilities. Complaint investigation was completed on 4/27/2021. No deficiencies were cited related to complaint.	N 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE